Fundholding 2004. Revised 2015

May 2015

Background

Australia has been experimenting with fundholding in primary healthcare for over two decades. Though early debate was heavily influenced by problems experienced in the United Kingdom, where fundholding was implemented primarily as a cost containment measure, the implementation of the funding model in the Australian healthcare system was largely focused on initiatives to improve the health and wellbeing of patients and, in particular on removing barriers to patients accessing appropriate services.[1]

Fundholding, as determined by the AMA Fundholding Resolution 27 May 2004[2], refers to a framework within which specified resources, agreed prospectively, are made available for a defined period, and from which a range of services are provided to a specific group of patients. It is a framework for funding a healthcare initiative to overcome the constraints of an existing funding structure by introducing flexibility within the healthcare system in relation to the fundholder/s (organisation holding the funds), the funds pool (resources managed by the fundholder), and the economic benchmark (contribution to funds pool by various financial stakeholders).[3]

Fundholding grants authority to the fundholder to ascertain service needs and try to meet those needs from the allocated funding.

In Australia, the major fundholding arrangements have traditionally been focused in the State/Territory based institutional sector, for example, where an Area Health Service holds the funds and purchases services from providers (i.e. hospitals and other agencies) in the local area.

More recently, the Government has introduced a number of fundholding programs including the Access to Allied Psychological Services (ATAPS) and the Mental Health Nurse Incentive Program. While Commonwealth fundholding programs have generally focused on other health services, it has experimented more recently with a fundholding model for after hours GP services, administered by Medicare Locals.

With the Government's increasing focus on exploring different models of primary healthcare funding fundholding will have an ongoing role to play in the future of primary healthcare in this country.

This position statement outlines key design principles the AMA believes should be considered for any system of fundholding in primary healthcare.

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[1] Beilby, J. and Pekarsky, B. (2002) Fundholding: learning from the past and looking to the future. MJA 2002; 176(7): 321-325

[2] AMA Fundholding position statement 2004 https://ama.com.au/position-statement/fundholding-2004

[3] Beilby, J. and Pekarsky, B. Ibid

Key issues

The evidence

There has never been a consensus on the real impact of fundholding on the cost and quality of care. A review of the evidence published by The King's Fund[4] found that fundholding created high transaction costs and a two-tier system in access to care, with different access for patients of fundholders and non-fundholders. There was evidence that fundholding GPs achieved more timely admissions for their patients, who therefore experienced reduced waiting times. However, evaluation of practice-based commissioning indicates that it has had little impact in terms of improving use of resources or providing better services.[5]

Earlier review of the Australian experience conducted by Beilby and Pekarsky[6] concluded that fundholding has a role in overcoming the constraints imposed on specific healthcare initiatives by the Australian healthcare system but the relationship between fundholding and patient health and well-being is largely dependent on the objectives and effectiveness of the overall initiative. A more recently evaluation of the ATAPS program shows that the program has successfully reached and addressed the unmet need of specific hard to reach consumer groups.[7]

Key concerns

Key concerns about fundholding include the potential for the funding model to undermine patients' access to health care according to need, erosion of the professional autonomy of individual doctors, and the potential for patients to be subjected to markedly rationed access to care.

AMA position

The AMA recognises the value of additional investment addressing identified gaps in access to health services through program funding, which may sometimes be called fundholding, and which encourages innovative locally appropriate solutions. In this context, the AMA believes fundholding may be appropriate:

- in circumstances where there is market failure, with existing funding arrangements being unable to address local health needs;
- for individual innovative programs and time limited projects;
- to address geographic-specific inequities; and
- to address chronic disease groups.

The AMA is of the view that when a fundholding program is considered, the proposed project/initiative must:

- not undermine the doctor/patient relationship;

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[4] The King's Fund (2010) Clinical commissioning: what can we learn from previous commissioning models? http://www.kingsfund.org.uk/topics/nhs-reform/white-paper/gp-commissioning

[5] Curry et al (2008) Practice-based commissioning: Reinvigorate, replace or abandon? The King's Fund http://www.kingsfund.org.uk/publications/practice-based-commissioning

[6] Beilby, J. and Pekarsky, B. Ibid

[7] Fletcher, et. al. (2012) Evaluating the Access to Allied Psychological Services (ATAPS) program – Nineteenth interim Evaluation Report https://ataps-mds.com/site/assets/files/1019/19th_interim_evaluation_report.pdf

- establish funding as additional to existing funds;
- include meaningful local GP-input to ensure that arrangements are designed to fulfil a demonstrated need;
- incorporate stakeholder consultation;
- rely on a local fundholder (not a national or international organisation/body and not an individual doctor or practice);
- have demonstrated local GP support for the choice of fundholder;
- incorporate clear quality improvement objectives;
- contain measures that ensure transparent management and accountability;
- not result in cost shifting;
- incorporate an appropriate public evaluation strategy;
- recognise and remunerate GP input; and
- define and separately fund administration costs; and

The proposed fundholding project/initiative is <u>unacceptable</u> if it incorporates any of the following features:

- contains perverse incentives;
- in relation to medical services, contains "cashing out" as a feature (for example cash out of MBS items);
- reduces access to patient care (rationing);
- reduces choice for patients;
- compromises clinical care;
- has a negative impact on existing GP services;
- increases red tape to GPs without appropriate remuneration;
- dilutes the independence of the doctor/patient relationship;
- creates an increased burden for GPs;
- compromises fee for service;
- establishes the fundholder as an individual or practice;
- establishes the fundholder as any national or international organisation/body;
- reduces the competitive GP market place; and
- shifts Government risk to the fundholder.